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ABSTRACT

A profile of Jamaica is sketched in this paper. Emphasis is placed on the nature, scope, and accomplishments of population activities in the country. Topics and sub-topics include: location and description of the island; population - size, growth patterns, age structure, rural/urban distribution, ethnic and religious composition, literacy, future trends; population growth and socioeconomic development - relationship of national income, relationship to size of labor force, relationship to social welfare expenditures for education and public health; history of population concerns; population policies - relevant laws; population programs - organization, operations; private efforts in family planning; foreign assistance for family planning activities; and research and evaluation. Summary statements indicate that Jamaica's population is rapidly increasing, the birth rate is high but decreasing, emigration has been reduced, the economy is slowly expanding, there is rapid urbanization but not accompanying industrialization or economic development, high unemployment, and increased expenditures in education, health, and family planning programs. References and a country map are given. (BL)

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Country Profiles

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JAMAICA

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Location and Description

Jamaica, a former British colony, independent since 1962, is located in the Caribbean area in the chain of islands called the Greater Antilles. It is situated approximately 90 miles south of Cuba and 100 miles west of Haiti. It is about 150 miles in length and approximately 50 miles wide with an area of 4,411 square miles. Only 20 percent of the country is arable land. The island is mountainous, with a tropical maritime climate. It is divided administratively into 14 parishes.

The economy of Jamaica relies heavily on agriculture, with sugar cane as the principal crop in value, followed by bananas. Major products include rum, cocoa, coffee, spices, citrus, and tobacco. As a result of current attempts to diversify the economy, mining, manufacturing, and tourism are gaining as sources of revenue and employment. Nevertheless, over a third of the labor force continues to be employed in agriculture, and industrialization proceeds only slowly.

Population Size

Total population. The total population of Jamaica was estimated at 1,954,000 in 1970. The island has a population density of over 460 persons per square mile. This figure is somewhat misleading, as the density of population per square mile of arable

land is perhaps twice that of the overall density.

Total number and average size of households. The 1960 Census recorded 401,771 households, with an average of 3.9 persons per household. Of the total number of households, 274,780 had male heads and 126,991 had female heads. The prevalence of female heads is due to a family structure and formation typical of the British Caribbean islands: there is a high percentage of illegitimate births, and the pattern of union formation includes visiting unions and common-law unions, as well as married unions.

Total number of women of reproductive age. As of 1970 there were an estimated 400,000 women in the age group 15-44. In 1960, 34 percent of the women aged 15 and over had never lived with a partner; 26 percent were living with a husband; 19 percent were living with a common-law partner; 19 percent were no longer living with husband or common-law partner; 2 percent were "not stated." Various studies¹ have shown that there is differential fertility by union type. Visiting unions have lower fertility than married unions. This difference is partly accounted for by the differences in stability among the unions. The greater the stability, the greater the portion of the fecund

period spent in a union, and the higher the fertility level (completed as well as current). Married unions are the most stable and visiting unions the least stable. This is illustrated by the findings of a study by Tekse comparing births by union status of mothers aged 30 to 34 in 1960.² Among these women, the average number of live births is 3.89. Those women who have never lived with a partner (visiting unions) have the highest percentage of childlessness (38 percent), and they also have the lowest number of live births per mother (2.75). This group is heavily weighted with those who have never been exposed to risk; that is, it includes not only women in visiting unions but also single women who have never been exposed to the risk of pregnancy. That their fertility is lowest should be expected. Women living with their husbands have an average of 4.29 children. Those living with a common-law partner have an average of 4.04 children. Those no longer living with their common-law partners have an average of 3.63 live births per mother.

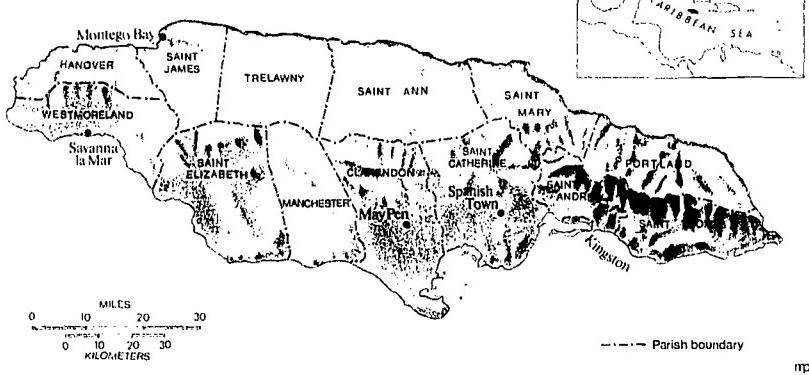
The Tekse study also showed that women who have gone beyond the primary grades in education have higher percentages of childlessness and lower averages in the number of live births per mother. This suggests that the better educated are less likely to enter a nonlegal union early in the childbearing ages or at any other time.

Age at marriage. The average age of women at marriage (29 years) is considerably higher than the average age at motherhood (18 years) in

¹ G. W. Roberts, *The Population of Jamaica* (London: Cambridge University Press, 1946). Judith Blake, *Family Structure in Jamaica* (Glencoe: Free Press, 1961).

² K. Tekse, "A Note on the Increasing Fertility of Jamaica's Population," Department of Statistics, Kingston, 1967.

JAMAICA



Jamaica. Over 70 percent of all live births are illegitimate; the percentage is higher among first births. Age at marriage is therefore not a meaningful variable as an indicator of the age at first exposure to pregnancy. According to the 1960 Census, 34 percent of all women had their first birth at 19 years or earlier, and 20 percent had theirs between 20 and 24. As with fertility levels, age at birth of first child seems to be related to the nature of the union that the woman enters. Women in common-law unions tend to produce their first child at an earlier age than women in all other types of unions.

GROWTH PATTERNS

At the time of the first Census in 1844, the total population of Jamaica was 377,400. It increased to 831,400 by 1911, and to 1,246,200 by 1943, an increase of over 300 percent in 100 years. In 1970 it was just under two million.

At the start of this century the birth rate was 39 per thousand and the death rate 23 per thousand. Because of the level of out-migration, the rate of population growth was comparatively low, at 15 per thousand. Since then the birth rate has remained high, except for a slight drop during and after World War II. The death rate has dropped consistently, and the level of out-migration has fallen. By 1960 the birth rate was 39 per thousand while the death rate had fallen to 8.7 per thousand, giving an annual rate of population growth of 3

percent. Presently the death rate is stabilized at about 7 per thousand. If the trend in the birth rate of the early 1960s had continued, the total population would have exceeded four million by the end of the present century; however, the rate has fallen slightly in the last two years.

AGE STRUCTURE

According to the 1960 Census, 52 percent of the population were under age 21. The age group 4 and under accounted for 17 percent, and only 3 percent were over age 70. Although infant mortality stood at 39.4 per thousand in 1965, the life expectancy of the Jamaican population has been increasing steadily with decreases in general as well as infant mortality. In the early 1960s the life expectancy for females was 67 years and for males, 63.

RURAL/URBAN DISTRIBUTION

Jamaica is predominantly rural, having only five urban centers with over 10,000 inhabitants. Kingston, the capital, is the main port on the island. According to the 1960 Census, Kingston and the surrounding urban area had a population of 376,500, or 23 percent of the total population. The other four major urban areas, Montego Bay, Spanish Town, May Pen, and Savanna la Mar, had a combined population of 62,190 persons, just under 4 percent of the total population. Extensive migration to the urban areas over the past decade has been a subject of concern: increasing

levels of unemployment and under-employment, and the spread of slum dwellings are particularly marked in the Kingston area.

ETHNIC AND RELIGIOUS COMPOSITION

The 1960 Census classified the population as 76 percent African; 15 percent Afro-European; 1 percent Chinese and Afro-Chinese; 3 percent East Indian and Afro-East Indian; and 3 percent "other." The proportion of Africans has remained stable over the years; the proportion of Afro-Europeans has steadily decreased; and, with inbreeding between the races, the Afro-Chinese and Afro-East Indians have increased in relation to the total population.

The two largest religious groups in Jamaica are Anglicans and Baptists (20 percent and 19 percent, respectively). These are followed by Church of God (12 percent), Roman Catholic (7 percent), Methodist (7 percent), Seventh Day Adventists (5 percent), and Presbyterians (5 percent). The Roman Catholic Church, though proportionately in the minority, constitutes an influential and close-knit group. It is predominantly urban, with 70 percent of its members residents of Kingston and the surrounding urban area.

LITERACY

Eighty-five percent of the population of Jamaica are reported to be literate, and the level is steadily increasing. The government has assigned high priority to expansion of education at all levels, as an important aspect of the program for economic development.

FUTURE TRENDS

On the assumptions that fertility and mortality remain at the 1970 levels and that net emigration remains at its present level, the population is expected to increase to 2,200,000 by 1975, 2,500,000 by 1980, and around 3.5 million by the year 2000. Assuming that mortality and migration remain at the 1970 levels, however, and that fertility declines continue and are speeded up as the effects of the national program in family planning are felt throughout the society, the population is expected to be 2,100,000 in 1975, 2,250,000 in 1980, and in 2000, 3 million.

Population Growth and Socioeconomic Development

RELATIONSHIP TO NATIONAL INCOME

The per capita gross national product (GNP) was US\$497³ in 1968. The per capita GNP has been increasing by an average of 2.3 percent per year since 1960, while the total real gross domestic product has been increasing by an annual average of 4 percent over this same period. The difference between these two rates of increase is due to population increase.

RELATIONSHIP TO SIZE OF LABOR FORCE

Because of the high rate of growth of the population, only about 40 percent of the population are in the labor force. The dependency burden is heavy and constitutes a deterrent to economic development. The labor force is approximately 65 percent male and 35 percent female.

In 1960 agriculture accounted for about 38 percent of the labor force, but this proportion is steadily declining as measures to industrialize and diversify the economy are implemented. (Fifty percent of all males and 18 percent of all females in the labor force were employed in agriculture.) Manufacturing accounted for 15 percent of the labor force (12 percent of the males and 20 percent of the females). Personal services accounted for about 30 percent of the female labor force. Construction employed about 13 percent of the males in the labor force.

As the population grows in size, the unemployment problem is becoming even more acute. "Unemployment is clearly the major social and economic problem in Jamaica. The levels of unemployment and underemployment are high and are in part the result of the rapid growth of population. Unemployment is particularly high in the case of women and young persons and there are serious difficulties facing school-leavers in regard to obtaining employment."⁴ About 15 percent of the labor force is generally unem-

ployed, and an even greater proportion is underemployed. This situation may well become more acute, for with the rapid population increase and declining productivity in agriculture, urbanization is taking place at a greater pace than the provision of additional jobs. Each year there are more persons entering the labor force than jobs being created or made vacant; thus, the backlog of jobless and underemployed increases. The government is taking steps to encourage industrialization and diversification of the economy. At the same time the government continues to place great emphasis on the agricultural sector in hopes of averting the flow of people into the cities.

RELATIONSHIP TO SOCIAL WELFARE EXPENDITURES

Education and public health are two areas of great concern and activity for the government and figure predominantly in future plans. Approximately 30 percent of the government expenditures are on social services, including education and health, with education accounting for about 15 percent and health for about 9 percent of all government spending. With the establishment of the national family planning program within the Ministry of Health, government spending in the area of health should be over 10 percent.

Public health. There is one hospital bed for every 600 persons. There is one doctor per 3,700 persons and one dentist per 19,400 persons. The island has 23 general and maternity hospitals and over 100 health centers providing simple medical services. Each of the 14 parishes has a medical officer in charge of health services with a staff of inspectors and nurses.

New hospitals and health clinics are under construction or planned, and present ones are being expanded. Dental and medical scholarships are given in order to ensure a supply of the professionals needed to reduce the acute shortages.

Public education. Despite the fairly high literacy rate of 85 percent, the overall level of education of the population is low. Inadequate educational facilities create a problem that is highly related to the level of economic development and the high birth rate.

According to the 1960 Census, approximately 15 percent of the population 15 years of age and over has never attended school; 77 percent has had primary education; 7 percent, secondary; and about 1 percent, professional training. Higher education groups are included in the secondary and the professional groups. In the early 1960s there were 40 secondary and over 700 primary schools. Education has very high priority in government planning and expenditures. All levels of education are rapidly being expanded, and free education for all Jamaicans is a goal that should soon be a reality. Currently, primary education is required but the dispersion of the population makes it difficult in practice.

History of Population Concerns

Traditionally, Jamaica has depended on emigration to alleviate its population pressure. Emigration has been spontaneous, but the government has encouraged it by facilitating travel. Early in this century, the majority of the emigrants went to South America and neighboring islands. In the 1950s large numbers emigrated to England. The 1962 British Immigration Act restricted the flow of emigrants, and currently there is no outlet for the large numbers of unskilled laborers. Emigration continues, but it is the better educated and more skilled who are leaving.

Private efforts in family planning were initiated in Jamaica over 30 years ago. In 1939, a private program, the Jamaica Family Planning League, was organized. It opened a clinic in Kingston and in 1954, a second clinic in St. Ann's Bay. In 1956 the Jamaica Family Planning Association was founded and became a member of the International Planned Parenthood Federation (IPPF). All efforts in population studies were consolidated under this organization. Most of its activities were limited to major urban areas. The government did not participate actively in any way. However, in 1956-1959 a study of attitudes toward family planning in Jamaica and of the Jamaican family structure was undertaken with the approval of the government.⁵ The study indicated

³ One Jamaican pound = US\$2.44. In 1969 Jamaica changed its currency to the decimal system. Now one Jamaican pound = 2 Jamaican dollars, and one Jamaican dollar = US\$1.25.

⁴ Government of Jamaica's Five-Year Independence Plan, 1963-1968.

⁵ J. M. Stycos and K. W. Back, *The Control of Human Fertility in Jamaica* (Ithaca: Cornell Univ. Press, 1964).

that the majority of Jamaican women were receptive to the idea of family planning, although few knew anything about it. Despite these findings, no official measures were taken to provide or encourage family planning.

Population Policies

Before 1966 both major political parties in Jamaica were reluctant to support family planning actively or to publicize a policy on population limitation for fear of political repercussions at the polls. As recently as the late 1950s, the Roman Catholic Church strongly opposed population limitation. Although Catholics constitute less than 16 percent of the population, they are an influential and well-organized group and represent an important voting bloc.

In the mid-1960s a number of developments made family planning a major issue. In 1964 Stykos and Back published their book *The Control of Human Fertility in Jamaica*, giving evidence that Jamaican women either were already using contraception or wanted to use it. This implied that public support for family planning was widespread. In 1965 the Roman Catholic Church opened a marriage guidance clinic in Kingston to teach the rhythm method of contraception. In 1966 the Minister of Health announced the establishment of a national family planning program within the Ministry of Health. Currently both major political parties support family planning.

RELEVANT LAWS

There are no restrictive laws regulating the manufacture, importation, or distribution of contraceptive methods in Jamaica. Both public and private channels exist for the distribution of all accepted contraceptive methods. There are no laws prohibiting sterilization; and even though this method of birth control is not widely used or publicized, it can be obtained for both males and females without undue trouble. Abortion is still illegal in Jamaica, although in some instances danger to the mental and physical health of the woman is accepted as legal grounds for abortion. (This law on abortion is similar to that in existence in England prior to the recent liberalization.) Reliable data are not

available on abortion, but there are indications that the number is large. The liberalization of the abortion law is a distinct possibility, since several groups are in favor of it.

Population Programs

ORGANIZATION

At its inception in 1966, the National Family Planning Program (NFPP) was made a unit within the Ministry of Health. By 1968 the National Family Planning Board (NFPB) was established as a policy formation body, appointed by the Minister of Health and responsible to him. The NFPB became a statutory body on 13 August 1970. The 12 members of the Board are selected from the professions, business, government, and the university. At the head of the Board is the Chairman and beneath him is the Chief Executive Officer, the Director of the program.

The administration of the Board is divided into three sections with definite responsibilities. The section heads, immediately responsible to the Director, are the Manager/Secretary with overall supervision of operations; the Program Officer in charge of clinical services and supplies, publicity and educational programs, and training; and the Statistical Officer, in charge of record keeping, data collection and processing, and evaluation.

The headquarters of the program is in Kingston, with 150 clinics located throughout the island.

OPERATIONS

Character of the program. Clinics are operated on a sessional basis; each session of about four hours duration is staffed by a doctor, two nurses or midwives, and an interviewer. In March 1970, the last month of the second year of operation, there were 360 clinic sessions held at the then 147 clinics. The frequency with which sessions are held at any one location depends upon the availability of staff and the level of client demand. Some clinics are open all day, five and a half days per week, while others are open as infrequently as once a month.

The NFPB has recently embarked on a postpartum family planning program. This program is at present confined to a few hospitals and is a special subprogram of an experimental nature.

Response to the general program has been high in all parts of the island, and clinic attendance has been increasing steadily. The number of clinics and the number of sessions have been increasing rapidly. During the first ten months of the present record-keeping system (November 1968-August 1969), the number of admissions and readmissions was 25,830. The total number of admissions as of June 1970 was around 40,000. The birth rate has shown a slight decline in the last two years from 36 to 33.

Information and education. At present there are few field workers employed by the NFPB. An education officer of the Board is assigned to every parish to assist the Regional Family Planning Officer in the program. The Bureau of Health is consultant to the Board on educational matters. The publicity program is carried out by a private firm.

Methods. The NFPB offers condoms, diaphragms, foaming tablets, creams, jellies, the pill, and the IUD. The rhythm method is explained to those who cannot or do not want to use mechanical methods. Free Papаниcolaou smears are obtainable at the family planning clinics. Contraceptive methods are discussed with the clients so that they may choose the method they want. All contraceptives are free of charge except the oral, for which a token fee of \$0.10 for a month's supply is paid if one can afford it. No one is denied service for lack of money.

Record keeping. When a client is interviewed on her first visit, relevant data are recorded in a file, and on subsequent visits her file is updated. At the Kingston headquarters of the NFPB, all information is coded and punched on cards for electronic data processing and storage. The record-keeping system is designed to provide data for evaluation of the program as well as to help clinicians account for the clients and compile lists of clients to be contacted for appointments.

Private Efforts

The Jamaica Family Planning Association, an affiliate of the IPPF, is the other organization primarily involved in family planning activities in Jamaica. The division of activities between the government program and the JFPA has not been fully resolved. Under the present agreement, the

JFPA is to maintain its existing clinics but not to expand its activities. Currently the JFPA operates two clinics, one in Kingston and one in the rural parish of St. Ann. The JFPA has an "encouragement visitors" (field workers) program which has been very effective in getting clients into the clinics and in ensuring continued use of the clinic facilities.

The JFPA offers its clients the same range of contraceptives as the NFPB. The JFPA has, from time to time, conducted small-scale special studies on various aspects of its operation and its clients.

In-service training is conducted for all employees by both organizations. The higher level employees, whenever possible, are given some training abroad.

Foreign Assistance⁶

Several foreign agencies have provided varied kinds of assistance to both the Jamaican national family planning program and the Jamaica Family Planning Association. The United States Agency for International Development (AID) acts as a consultant to the National Family Planning Program on administration, education, communications, and statistics. AID has provided assistance in Papanicolaou smear testing of the clients and in obtaining contraceptives and equipment. AID is also assisting the University of the West Indies in training, research, and evaluation related to family planning. The Ford Foundation has provided the national program with a consultant in record keeping and evaluation and has provided the University of the West Indies with grants totaling \$338,000 for training and research in population fields. The Population Council has been active in the government postpartum program as well as an IUD program at the General Hospital in Kingston. The Council has also provided small grants to the University of the West Indies. The Pathfinder Fund has donated contraceptives and family planning literature to the national program. Extensive assistance has been provided to the Jamaica Family Planning Association

by the International Planned Parenthood Federation (IPPF); and the Rockefeller Foundation has made a grant to the Association to make a family planning film. The World Bank has made a loan of \$2 million to the Jamaican government for the construction of rural maternity centers and the expansion of the maternity facilities at the General Hospital in Kingston. Other agencies such as the World Health Organization-Pan American Health Organization (WHO-PAHO), Church World Service, and the United Nations Fund for Population Activities have assisted to a lesser extent. Foreign scholars working with the local universities have put together a good deal of literature on the Jamaica population: Roberts (1957), Blake (1961), Stycos and Back (1964), and Tekse (1967). (See last section of this profile for full references.)

Research and Evaluation

The NFPB has not to date conducted any special surveys on either its clients or the general population. Instead, the NFPB is presently relying heavily on its record-keeping and evaluation system for needed information on the fertility and contraceptive behavior of its clients. The following section on accomplishments of the program and characteristics of acceptors is derived from the record-keeping system.

The number of clinics in operation under the NFPB increased from 94 in January 1969 to 137 in January 1970 and to 150 in August 1970. In the year 1969 an average of 2,330 new acceptors was recruited monthly. As of August 1970, 47,000 women had been admitted as clients, accounting for almost 12 percent of the estimated 400,000 women in the age group 15-44. Basic information on acceptors in 1969 has been compiled from record cards, as follows.

By method. Over 60 percent of the 25,831 acceptors in the program as of August 1969 chose the pill; about 14 percent, the IUD; 2 percent, the diaphragm; and 12 percent, the vaginal methods. Of those women who initially chose the vaginal method, 1,883 or 57 percent changed to another method within the year, generally either the pill or the IUD.

By satisfaction. Sixty-six percent of the women who revisited clinics in

1969 were satisfied with their contraceptive method, 4 percent disliked their method, 1 percent complained of pain, and 28 percent registered "no response."

By source of referral. During 1969, nurses referred 34 percent of all acceptors to the clinics; friends, 28 percent; "encouragement visitors" (field workers), 16 percent; and doctors, 5 percent. The sizable percentage of referrals by friends shows the effectiveness of word-of-mouth communication.

By outcome. The number of pregnancies reported by clients of the family planning program in 1969 was 486. (This number does not include the women who did not return to the clinic and who could not be reached for follow-up.)

By pregnancy history. A percentage distribution of new 1969 acceptors shows that the program is attracting a cross-section of women of all parity levels:

Number of events	Pregnancies	Live births	Living children
0	2	2	3
1	11	12	13
2	15	16	17
3	15	16	17
4	14	15	15
5	12	12	12
6	9	9	9
7 and over	22	18	14
Total	100	100	100
N=25,831			

More detailed information on the characteristics of acceptors has been compiled for women admitted and readmitted in the first ten months of record keeping (November 1968-August 1969). During this period 25,831 clients were admitted or readmitted.

By age. The table below shows the percentage distribution of clients and of the projected 1970 population of childbearing age, by age group:

Age group	Family planning clients	Female population
15-19	0.4	24.3
20-24	9.0	19.3
25-29	29.5	16.9
30-34	30.5	15.0
35-39	19.0	13.4
40-44	11.6	11.1
Ages 15-44	100.0	100.0

⁶ The information in this section is obtained mainly from *Population Program Assistance*, U. S. Agency for International Development (Washington, D. C.: October, 1970).

A primary aim of the program should be to attract women under 25 years of age and help them to delay their first pregnancy and hence to raise the age of first pregnancy and first childbirth.

By education and occupation. Ninety-two percent of acceptors have had some elementary school education; 2.2 percent, no education; and the remaining 5.8 percent, education beyond the primary grades. Nine percent of the women are white-collar workers. The overwhelming majority are housewives, or domestic or personal service workers. Ten percent of the women's partners are white-collar workers, while the overwhelming majority of the partners are blue-collar and agricultural workers. Over 11 percent of the male partners were reported as unemployed at the time of the client's admission to the program. These findings are consistent with the program's orientation toward women of lower economic status. In Jamaica as elsewhere, the middle and upper classes primarily use private sources for contraceptive methods.

By religion. All religious groups are represented among the clients. Roman Catholics comprise 9.45 percent of acceptors; Baptists, 19.37 percent; and Anglicans, 13.6 percent.

By rural/urban distribution. The urban area of Kingston-St. Andrew accounts for almost 40 percent of the clients. In general, the more urbanized the parish, the better represented it is among the clients.

By previous use. Of the 25,831 clients who were admitted or readmitted during the period November 1968-August 1969, 63 percent had never used a method of contraception previously, and 37 percent had used

one or more methods before. Of those who had used a method before, 53 percent had done so in the program and were therefore readmissions within the new record keeping system; 19 percent had been clients of the JFPA; 21 percent had purchased contraceptives at drugstores; and 7 percent had received contraceptives from other sources.

By purpose. When asked about their reasons for using contraception, 65 percent of current users responded that they were trying to space their pregnancies and 35 percent said they wanted no further pregnancy.

Summary and Conclusion

Jamaica's population is rapidly increasing. The birth rate is high but has shown a slight decrease over the last two years. The death rate is low and falling very slowly. Emigration, except among skilled and professional workers, has been considerably reduced. The economy is expanding but efforts to move swiftly are hampered by the high rate of population increase. High rates of natural increase and rural-urban migration are contributing to a rapid rate of urbanization, but this is not accompanied by rapid industrialization and economic development. Thus, the unemployment rate remains high, slums increase, social dislocations and societal alienation grow, and poverty becomes more obvious.

The concern for betterment of living conditions and economic development has led to increased expenditures in education, health, provision of jobs, and, more recently, in a family planning program aimed at reducing the rate of population growth. The family planning program is mov-

ing ahead in the establishment of clinics and the recruitment of clients; over 45,000 women are now members of this program and it is not unrealistic to attribute a part of the recent declines in the birth rate to the work of the program. Further declines are expected as the program extends its operations and attracts a larger proportion of the fecund women.

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Current Publications in Population/Family Planning, a four-page abstract/bibliography issued every other month and consisting of titles deemed by the Council staff to be of particular interest to administrators and scholars in the field. Available in English only.

These publications are issued without charge. Persons wishing to receive any or all of them should address their requests to: Information Office, The Population Council. Bulk orders may be requested for educational purposes.